SURVEYING THE VIEWS OF ALCOHOL AND DRUG TREATMENT PROVIDERS ON FAMILY INVOLVEMENT IN TREATMENT

by

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ABSTRACT

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This study examined the views of alcohol and drug treatment providers on family involvement in alcohol and drug treatment. A survey was distributed to one hundred certified midwestern alcohol and drug treatment programs during the spring of 1997. Forty-nine of the surveys were returned.

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I would like to take this opportunity to thank the people in my life whom have made it possible for me to complete this Plan B Thesis. My wife Laura has been instrumental in motivating me to finish this paper. Her words of encouragement were what I needed to keep me going. Thank you, Dr. Barnard for becoming my advisor, despite your busy schedule. And finally, thank you to all of the unnamed respondents to my survey. Without you, I would have nothing to write about.

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Chapter 1

Introduction

Marriage and Family Therapy is not a new concept in the Sociological Sciences. Nor is the field of Alcohol and Drug Abuse Treatment. However, there is very little attention paid by researchers of the use of family therapy in addiction treatment. In fact, for some time now studies have outlined the role of family relationships in the creation and maintenance of drug and alcohol problems (Blum, 1972; Kaufman, 1985; and Stanton, 1985). According to family systems theory, alcoholism is embedded within the family system (O'Farrell & Murphy, 1995). Alcohol becomes a central organizing principle that affects all family members. Working as this principle, alcohol becomes a stabilizer for the family system. As a homeostatic maintaining force, alcohol helps the family avoid uncomfortable and necessary changes (Stienglass, Bennett, Wolin & Reiss, 1987). Research by Edwards and Stienglass (1995) suggests that active involvement of families, especially spouses, as an important component of the comprehensive treatment approach would be a reasonable and prudent direction to take. Despite all of this, family therapy is still practiced inconsistently in contemporary drug abuse treatment settings (DATOS-A, 1993; Menicucci & Wermuth, 1989)

Drug and alcohol abuse is a problem that pervades our society. The consequences affect nearly every aspect of the world we live in from the roads we drive on to the health insurance premiums that we pay. Daley (1988) found that the individual with alcoholism or drug addiction is at a greater risk for a myriad of problems, including medical, psychological, psychiatric, interpersonal, social, occupational or academic,

family, spiritual and financial complications. In 1999, the Substance Abuse and Mental Health Service Administration (SAMHSA) conducted the National Household Survey on Drug Abuse. They found that an estimated 3.6 million Americans (1.6 percent of the total population age 12 and older) were dependent on illicit drugs. An estimated 8.2 million Americans were dependent on alcohol (3.7 percent). Of these, 1.5 million were dependent on both. Overall, an estimated 10.3 million people were dependent on either alcohol or illicit drugs (4.7 percent).

Lipps (1999) indicates in a review of literature that two theories of family therapy are most popular in the treatment of alcohol problems: behavioral family therapy and family systems theory. However, after decades of research no single treatment approach emerges as the most effective in the treatment of alcoholism. In their review of literature Kahle and White (1991) found that the attitude of a mental health practitioner toward the alcoholic patient is pertinent to treatment outcome.

Statement of Problem

The purpose of this study is to describe some of the opinions and views of professionals regarding the effectiveness of family involvement in the treatment process. This study will focus on the following objectives:

1. Determine the level of satisfaction among respondents with their own family programming.
2. Determine the most common types of family involvement by the respondent's treatment facility.
3. Determine the most common changes they would make to their programming.

4. Determine which family member is seen as most important to the treatment process based on rankings done by the respondent.

Definition of Terms

For the purpose of clarification, the following terms need to be defined.

Alcoholism: Taken from Encyclopedia.com, a disease characterized by impaired control over the consumption of alcoholic beverages.

Drug Addiction: Taken from Encyclopedia.com, chronic or habitual use of any chemical to alter states of body or mind for purposes other than medically warranted.

Family Therapy: Taken from Encyclopedia.com, a form of psychotherapy dealing with the improvement of family relationships and the emotional environment, based on the assumption that identified psychological problems in one family member are not isolated, but are the result of unhealthful interactions within the entire family unit.

Physiological Dependence: Taken from Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), evidence of tolerance or withdrawal.

Tolerance: Taken from Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), defined by either a need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with continued use of the same amount of the substance.

Withdrawal: Taken from Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), manifested by either the development of a substance specific maladaptive behavioral change that is due to cessation or reduction in prolonged and heavy substance

use; or the syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Chapter 2

Review of Literature

Introduction

As the following review of literature reveals, there is an ever-increasing amount of research regarding family therapy. Likewise, there is a wealth of information and research on substance dependence treatment.

This literature review focuses on two family therapy approaches, behavioral family therapy and family systems theory. First, there will be a specific review of the two distinct models of family therapy; followed by an overview of substance addiction and treatment. Then there will be a review of two specific models of addiction treatment selected by the researcher. They are the Abstinence Model/AA model and the Moderation or "Controlled Drinking" Model. It should be noted that this review is intended to be representative rather than comprehensive. Each of the areas discussed in this review has an extensive body of related literature and a comprehensive review was deemed to be beyond the scope of this project.

Various Models of Family Therapy

There are numerous models of family therapy utilized by treatment facilities and private providers. The list includes models such as Structural family therapy (Minuchin, 1974); Strategic family therapy (Haley, 1963); Behavioral family therapy (Patterson, 1971); Psychoeducational family therapy (Anderson, 1983); Communication family therapy (Jackson, 1960 Von Bertalanffy, 1968); Bowen's family systems therapy (Bowen, 1976); and Experiential family therapy (Whitaker & Keith, 1981).

For the purpose of this study and in the interest of time and space, I will focus only on the Behavioral and Bowen's family systems therapy as each pertains to this particular research.

Behavioral Family Therapy

The model for behavioral family therapy borrows heavily from theories of behavior from scholars like Alfred Bandura. Bandura (1978) posits that children learn from their parents and that parenting skills are often singled out as causative of problematic behavior. He also points out that anything that reinforces, extinguishes or predisposes an individual to exhibit a behavior is relevant to the presenting problem as well. Because the idea is that all behaviors both deviant and pro-social are learned, the goal of therapy is to teach parents appropriate behavior reinforcement and extinction skills (Griffin & Greene, 1995). Involving the family in behavioral therapy allows them to learn to modify the environment so those behaviors that reinforce drinking are changed or removed. Family members learn to provide positive reinforcement for sobriety and negative reinforcement for drinking (Edwards & Stienglass, 1995). Family cohesion has a major impact on long term treatment outcomes for clients with alcohol problems (Moos, Finney & Cronkite, 1990). As stated previously, alcohol related behaviors appear to serve a purpose in helping families maintain their stability through problem avoidance.

If we believe that drinking behaviors are embedded in family systems we need to consider the family or at least the couple as an appropriate unit of treatment (Lewis, 1994). In fact several studies have shown promising results in using behaviorally based couples counseling with alcohol affected clients in early recovery (O'Farrell, 1992).

O'Farrell, Cutter and Floyd (1985) found that drinkers that received both behavioral marital counseling and alcoholism counseling had better marital adjustment scores, fewer days separated and fewer days spent drinking. Noel, McCrady, Stout, and Fisher-Nelson (1987) determined that patients who participated in behavioral marital therapy stayed in treatment longer than those who received minimal family therapy or alcohol focused spouse involvement. In their review of literature, Sandberg et al. (1997) found that behavioral therapy has proven itself to be effective in reducing the alcoholic's drinking among other disorders and problems.

Bowen Systems Family Therapy

This theory states that emotional illness reflects the cumulative effects of functioning across at least 3 generations. Bowen's (1961) theory was originally used in treatment of families with a schizophrenic member. However, the tenets set forth can be generalized to families with an alcoholic member. The theory posits that individuals face a fundamental tension – attempting to satisfy opposing needs for familial connection and personal autonomy. Members who are not able to reach a balance of these needs react to momentary emotion and family contact as either excessive or nonexistent. One of the main constructs of the theory is triangulation. Griffin and Greene (1999) define triangulation as an unhealthy subsystem or dyad (husband & wife) that seeks relief from dysfunction by involving a third party in their interaction (child). When triangulation involves children it can cause them to exhibit emotional disturbances that can persist into adulthood.

Addiction – An Overview

The earliest recorded reference to alcohol addiction can be found during biblical times. In the eighteenth century physicians led by Benjamin Rush began to consider abnormal alcohol use as a disease (Vaillant, 1983). And now, in the United States alone, there are an estimated 10.3 million people dependent on either alcohol or illicit drugs or both. Miller and Rollnick (1991) describe addiction as follows:

> A defining characteristic of addictive behaviors is that they involve the pursuit of short term gratification at the expense of long term harm. Often the person is quite aware of damaging consequences and as resolved to control or abandon the addictive behavior, yet time and again returns to the old familiar pattern.

Theories of Addiction

Until recently, drug addiction was treated independently from the context of social influences that promote, support and maintain addictive behaviors. There are many ways in which to treat addiction and numerous theories and approaches to the whole process. The following is a brief summary of only a few of these approaches that are frequently used in the treatment of alcoholism and other drug addiction.

Disease Model

This is by far the most widely recognized and frequently used theory of addiction. In 1935 a man named Bill W. and a physician from Ohio founded a group called Alcoholic's Anonymous (AA) to provide a structure for fellowship and support to alcoholics recovering from this disease. AA is seen as a cornerstone of the disease concept because it was one of the first organizations to utilize the word disease in its

literature on alcoholism. The method of treatment that has spawned from the ideas of AA is also known as the Minnesota Model. This is mainly due to the fact that this form of treatment was first practiced in Center City Minnesota. In 1952, E. M. Jellinek published an article that proposed a pattern of behavioral and physiological symptoms defining alcoholism as a disease. These include the previously mentioned withdrawal and tolerance symptoms that are the foundation of diagnosis found in the DSM IV. The basic tenet of the disease concept is that the disease of alcoholism is considered to be within the individual and not their responsibility. The AA Big Book states that "Alcoholism is a disease for which there is no cure, only recovery". Marlatt and Gordon (1985) propose that this idea is both a major strength and a major weakness of the disease model.

Genetics Model

According to this theory of addiction, individuals are predisposed to addiction by their own genetic makeup. This theory is easily interwoven with the disease concept because they both imply little or no responsibility on the part of the patient. The main research that backs up the idea that alcoholism can be inherited is in studies of identical twins raised apart from each other. The studies found that regardless of environment or other social causes, if one twin was predisposed to addiction so was the other (Stabenau & Hesselbrock, 1983). The basic tenet here is that twin studies can be generalized to the entire population thereby making it possible that an individual could have addiction passed down from one generation to the next.

Biopsychosocial Model

This is the most recent of theoretical paradigms. It explains addiction in terms of genetic, medical, psychological and sociocultural aspects (Zucker & Gomberg, 1986). The basic tenet of this model is that addiction is not rooted solely in one area, i.e. genetics or medicine, but rather is a result of a combination of those things. This model incorporates approaches from the various fields that it is associated with (Psychology, Sociology, Medicine, etc.).

Approaches to Addiction Treatment

There are a number of different approaches to treating individuals and families with addictions. For the purposes of this study, this researcher chose to focus on two opposing approaches. An overview of those approaches follows.

Abstinence Based Approach

This form of treatment is the most widely utilized and highly recognized form of addiction treatment. It is known as the AA model because it is derived from the basic principles of Alcoholic's Anonymous. The fundamental concept is that alcoholism is an addiction and as such is an independent disease. This method of treatment was first practiced in Center City, Minnesota at Hazelden Center. For that reason it has also become known as the Minnesota model. The main treatment goal is a commitment to complete abstinence from the substance achieved by following the 12 established steps (Miller, 1995). Many treatment centers that practice this method consider anything less than complete abstinence to be unacceptable as a treatment goal. Therefore, treatment

models that encourage the drinker to cut back use rather than totally abstain, are seen as the antithesis of the true model.

Moderation Based Approach

This is the most controversial of alternative treatment methods. Moderation is also called “controlled drinking”. Moderation theorists posit that through behavioral change techniques, true control can be achieved. The focus is not on abstaining from the substance completely, rather on controlling the behavior surrounding the drinking in an effort to reduce the using behavior. Miller and Hester (1989) found that while studies demonstrate short-range effectiveness in small controlled studies, there is no evidence that these methods have long term application to the treatment of addiction. Zygarlicki and Smith (1992) examined whether marriage and family therapists think that controlled drinking is ethical. Surprisingly, 23.5% of the respondents surveyed agreed that this approach is ethical. This was an overall increase from previous research.

Family Therapy in Conjunction with Addiction Treatment

Until recent years, little attention has been given to the role of families in the treatment of addiction. It has long been theorized that many of the roots of addiction lie within the family. However, the focus of treatment has been on healing the individual with problems first and foremost. In his research, Vroom (1986) found that while alcoholism counselors are becoming aware of the importance of family involvement in treatment, family therapists are also becoming aware of the dynamics between the family

system and drugs or alcohol. Many family therapists have cited the desirability of using AA as an adjunct to family therapy when treating problem drinking or alcoholism issues (Kaufman, 1985; Kaufman & Pattison, 1982). There is a movement toward the merging of family therapy and addiction treatment and acceptance of this movement is ever increasing. The question becomes one of effectiveness. What affect does family involvement in treatment have on outcomes?

Treatment Outcomes and Efficacy

There are numerous studies regarding the effectiveness of family therapy in treating addiction. The consensus, however, appears to be that there is no consensus as to which treatment approach is most effective. In regards to addiction alone, Miller (1995) concluded that there are a large variety of treatment methods that appear to work in the short term. However, only one treatment method appears to work in the long run. Namely, abstinence based treatment. In regards to family therapy in the treatment of addictions, Lipps (1999) found that no one approach emerged as the most effective. This is largely due to the heterogeneity of the population of drug and alcohol users. What works for one family or individual does not necessarily work for all. Lipps (1999) also cited the need for future research. Sandberg et al. (1997) found that behavioral marital therapy proved itself to be effective in decreasing the alcoholic's drinking. They also state, however, that more research is needed to determine what types of clients benefit most from this form of treatment. Edwards and Steinglass (1995) found that behavioral family therapy is most effective in treating alcoholism when the partners have a strong investment in their marriage. There is also a strong correlation in individual treatment

between motivation and treatment outcome. Results seem significantly better when a couple, family or individual is motivated to make changes. If there is resistance or denial, effectiveness of family involvement and of treatment in general becomes less clear-cut. There were a number of articles on Bowen family systems therapy, none of which outlined efficacy of the approach. More research is necessary to determine that aspect.

Summary

The literature indicates that family involvement is extremely effective in the initial stages of treatment, but becomes considerably less so in the later stages (primary care, and aftercare). Treatment outcome is closely linked to personal and familial motivation which makes it difficult, if not impossible, to determine exactly how effective a certain approach is. No one approach has defined itself as the ultimate in effective treatment. There are a number of ways to treat addiction and numerous ways to treat families. One approach not to be taken is to continue to assume that one must treat the addict before they can treat the family problems of the addict. In the opinion of this researcher, there is only one way to treat families with addiction – together.

Chapter 3
Methodology

Introduction

This chapter describes the research objectives for this study, the subjects and how they were selected for inclusion in the study. Next, there will be a discussion of the instrument used to collect the data including validity and reliability factors and general content. This will be followed by an illustration of procedures for collection of data and a description of the data collected. Finally, the chapter concludes with an outline of the limitations of the study.

Research Objectives

This researcher determined the objectives based on the anticipated responses to the self-derived survey. The researcher felt that the following four areas were most likely to be addressed and responded to in the survey:

1. Determine the level of satisfaction among respondents with their own family programming.
2. Determine the most common types of family involvement by the respondent's treatment facility.
3. Determine the most common changes they would make to their programming.
4. Determine which family member is seen as most important to the treatment process based on rankings by the respondent.

Subjects

This researcher selected 100 alcohol and drug treatment facilities at random from a listing of all treatment facilities in the state of Wisconsin. Forty-seven of the surveys were returned. To achieve random selection, the names of all AODA treatment facilities were put in a hat, the first 100 names drawn were utilized. The survey packet was sent to the attention of the senior counselor or therapist in that facility. The decision to send this survey to the counselor rather than the program director was based on the belief of the researcher that the counselor would have a better feel for the program and the impact of the family in the process. A majority of those surveyed (30) indicated their age to be 35-50 years. Twenty-six out of forty seven responders were male. There were also a majority of the responses indicating 15 plus years in counseling practice, 5 or more of those years being in chemical dependency counseling. Of those surveyed, twenty-six people indicated 5 or more years in recovery from addiction.

Instrumentation

Since there were no established questionnaires or inventories that directly related to the subject of this study, this researcher compiled his own survey. This researcher attempted to ask questions that would reveal information from responders that directly related to the research objectives. A statistical analysis was not done on the information, as it was not deemed to be within the scope of the project. The validity and reliability of the instrument is not immediately known, as the questionnaire has not been subjected to any scientific testing.

Procedure

A packet of information was mailed to the subject facility attention Senior Counselor/Therapist. The packet included a letter of introduction explaining the voluntary nature of graduate research and instructions for completing and returning the instrument (Appendix A). The packet also included a statement of informed consent (Appendix B), the questionnaire (Appendix C), and a self addressed, stamped envelope for return of the questionnaires. Return of the informed consent statement was not required. Identification numbers were affixed to the questionnaires simply as a method of tracking the number of surveys mailed and returned. The numbers were not linked to the identification of the subject facility in any way. There was no planned follow-up to the questionnaire.

Data Analysis

Data analysis consisted of a simple tally of the responses to each question on the instrument. Simple majority was used in describing the results.

Limitations

This researcher acknowledges the following limitations regarding the methodology of this study:

1. Unclear questions on the instrument may have resulted in misunderstood notions or misinterpretations of the question. This researcher did not have an opportunity to answer any potential questions.
2. The instrument may have been written with the researcher's bias rather than from an objective standpoint.

3. Subjects were representative of only a small portion of all treatment providers. It would be difficult to generalize the results of this study to other populations based on the sample size.
4. Given that the questionnaire was written and designed by the researcher, there are no reliability or validity factors. The instrument may not be statistically valid.

CHAPTER 4
RESULTS

Introduction

This chapter will present the results of this study that investigated the views of alcohol and drug treatment providers on family involvement in treatment. The demographic data will be reported first followed by a description of the findings based on their corresponding number on the survey. Finally, a discussion of the predictable portions of the results as well as the results the researcher found to be surprising.

Demographic Information

Forty-seven individuals responded to the survey out of a possible 100. Table 1 presents the frequency counts and percentages for responder age. A majority of responses came in the 35-50 age bracket (63.8%).

TABLE 1

Frequency Data for Responder Age

	Responders (n=47)	
Responder Age Brackets	**Frequency**	**Percentage**
Under 35	**2**	**4.3**
35-50	**30**	**63.8**
50 Plus	**14**	**29.8**
No Response	**1**	**2.1**

Table 2 shows the percentage of those surveyed that are male versus female. There were two non-responders to this question.

TABLE 2

Frequency Data for Gender

	Responders (n=47)	
Gender	**Frequency**	**Percentage**
Male	**26**	**55.3**
Female	**19**	**40.4**
No Response	**2**	**4.3**

Table 3 displays the frequency and percentage for number of years in counseling practice. The responders had to choose between four brackets: less than 5 years, 5-10 years, 11-15 years and 15 plus years. The responses to this question were pretty evenly spread, but the majority goes to 15 plus years with 34% of responses.

TABLE 3

Frequency Data for Number of Years in Counseling Practice

	Responders (n=47)	
Number of Years in Counseling Practice	**Frequency**	**Percentage**
Less than 5 years	**2**	**4.3**
5-10 years	**13**	**27.7**
11-15 years	**13**	**27.7**
15 plus years	**16**	**34.0**
No Response	**3**	**6.4**

Table 4 shows the frequency of responses to the question of how many years of past training or employment in the chemical dependency field. Thirty-five of those surveyed determined the most common response to be five or more years (74.5 %).

TABLE 4

Frequency Data for Number of Years of Past Training or Employment in Chemical Dependency

	Responders (n=47)	
Number Years Past Training/Employment	**Frequency**	**Percentage**
Less than 1	**0**	**0**
1-5 years	**11**	**23.4**
5 or more	**35**	**74.5**
No Response	**1**	**2.1**

Question number 5 pertained to the number of hours per week the person surveyed was working. Full time work was indicated a majority of the time with 45 out of 47 (95.7%) responses being 30 hours or more per week. Only 2 responders (4.3%) indicated 20 or less hours worked per week.

Question number 6 was optional for the subjects, as it was an indicator of a sensitive subject for some people: number of years in recovery from addiction. Table 5 shows the percentage and frequency results for the responses to this question. A majority of responders indicated five or more years in recovery. It is interesting to note that 20 of the responses (42.6%) were stating that this question was not applicable to them or that they were not in recovery.

TABLE 5

Frequency Data for Number of Years in Recovery

	Responders (n=47)	
Number of Years in Recovery	**Frequency**	**Percentage**
Less than 3 years	**0**	**0**
3-5 years	**1**	**2.1**
5 or more years	**26**	**55.3**
Not Applicable	**20**	**42.6**

Question 7 was in regards to the type of treatment facility the responder worked in. Table 6 displays the frequency and percentage results for this question. The answers to this question were not as clear-cut as previous ones due to the wording of the question. The researcher asked the participants to circle all answers that applied to their facility. This resulted in multiple answers by the same person. To report this result, it was deemed prudent to use the most frequently chosen option. Each answer had 47 possible affirmative responses and hence the percentage is taken from that number on each category. Similar circumstances surround questions 8 and 9. Question 10 was thrown out completely as the researcher was not able to interpret the responses into anything that pertained to the study.

TABLE 6

Frequency Data for Type of Treatment Facility

	Responders (n=47)

Table Continues

Table 6 continued

Type of Treatment Facility	Frequency	Percentage
Detoxification	**10**	**21.2**
Inpatient Counseling	**13**	**27.7**
Outpatient Counseling	**36**	**76.6**
Long Term Residential	**13**	**27.7**
Intensive Outpatient	**15**	**31.9**

The most common response to the type of facility question was Outpatient Counseling. The average length of stay or involvement in the program based on responses to question 8 was 1-6 months (20.4%). The most common treatment setting was the mental health clinic (38.3%). Tables 7 and 8 show these results.

TABLE 7

Frequency Data for Average Length of Stay

	Responders (n=47)	
Average Length of Stay	**Frequency**	**Percentage**
10 Days or less	**1**	**2.1**
11-20 Days	**3**	**6.3**
21-30 Days	**3**	**6.3**
1-6 Months	**30**	**20.4**
6 Months or longer	**7**	**14.9**

TABLE 8

Frequency Data for Treatment Setting

	Responders (n=47)	
Treatment Setting	**Frequency**	**Percentage**
Private Practice	**12**	**25.5**
Community Program	**6**	**12.8**
County Funded Program	**14**	**29.8**
State Funded Program	**10**	**21.3**
Federal Funded Program	**4**	**8.5**
Group Home Setting	**5**	**10.6**
Halfway House	**6**	**12.8**
Residential Treatment	**12**	**25.5**
Hospital	**9**	**19.1**
Mental Health Clinic	**18**	**38.3**
Correctional Facility	**0**	**0**

The content of question 11 was in regard to the responder's opinion about family programs. Participants were asked to choose the response that best described their opinion. The most common response was that treatment can be successful without family programs but is not recommended (38.3%). What is surprising to this researcher is that this majority is an indication that providers of treatment still do not have much faith in

their family programs. This borderline apathy from the provider may be part of the reason that families are not always involved in treatment. Either there is a lack of participation from family or minimal effort to recruit their participation.

Question 12 on the survey was in regards to which person the counselor deemed to be most important in terms of attendance for the family program. 68.1% responded in favor of the spouse as the most important family member to be in attendance. 25% either did not respond or indicated no one person as most important. These participants indicated that level of importance depends on such things as level of involvement, age and type of relationship.

Questions 13, 14 and 15 were set up as a gauge of how much of the program success, or lack of it, the responder would attribute to the family program. However, question 13 directed the responder to skip the next two questions if they answered no to it. The surprising information that was gathered from this question is that a majority of responses were negative. 51.1% stated that their facility did not conduct follow up research on their patients. Of the remaining percentage that indicated they do follow up, 23% were optimistic about their family program, attributing about half of their program success on their patient being involved in family programs.

To determine the level of satisfaction with the family program of their facility, the counselor was asked to choose a response to question 16 that best describes their satisfaction. 56.9% indicated they were somewhat or very satisfied with their family program. Question 17 was also related to this topic. The responder was asked to indicate what changes they would make to their program. Due to the nature of the question, there

were multiple responses by the same individual. The number of possible responses to each answer (47) determined the percentage. 48.9% indicated they would initiate more intensive immediate family involvement.

Summary

This study produced a number of interesting insights to family involvement in treatment of addiction. Overall, the participants were satisfied with their family programs and indicated that more intensive family involvement would be desirable. Determining the most common type of family involvement was one of the research objectives. This researcher was unable to determine this from the survey responses. This was mainly due to the ambiguous nature of the question. The spouse is seen as the most important family member to have involved in the treatment process.

CHAPTER 5

Summary and Recommendations

Introduction

This chapter provides a brief summary of the study, recommendations for further research and for application of the research findings.

Summary

The purpose of this study was to describe some of the views of treatment professionals on family involvement in the treatment of addiction. Overall, the results indicated that most providers of addiction treatment are satisfied with their family program but also would prefer more intensive family involvement. The spouse is seen as the most important family member to have involved in the treatment process. A few of the respondents indicated that it would be prudent to have the parents of the patient involved but that time and constraints from third party funding usually hampers their efforts to involve them. Some of the responses seemed to indicate that they are indifferent about the effects of their family programs on the outcome of treatment. Most believe that treatment can be successful without family involvement. Some stated that families are completely disengaged from their patients. Most programs surveyed stated they did not do follow up studies on their patients. This was rather surprising information for this researcher. Logic would seem to dictate that in order to determine the success of your program, one would need to follow patients after discharge and continue to assess their

status. While this can be a tremendous undertaking, the benefits should outweigh the drawbacks of doing it.

Recommendations

For Application

Providers of addiction treatment may be able to benefit from the research findings by using the insights provided to improve their family programs and work harder to involve families in their treatment process. Families dealing with addiction could use this information to help to spur providers into more active involvement with family programming.

There has been much movement toward integrating family therapy with addiction treatment. Some of the opinions stated in the surveys indicate that providers don't consider family therapy as completely necessary for successful treatment.

For Further Research

There is a need for more research on the topic of matching treatment of addiction with a specific mode of family therapy in order to increase effectiveness of treatment. There is also a need for more outcome type studies that include family therapy in the treatment of addiction. Further research in the area of controlled drinking and other alternatives to the traditional treatment modalities is also needed.

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APPENDIX A

Greetings! ATTN: Senior Counselor/Therapist

My name is Brian Gilson. I am a graduate student at UW-Stout. I am currently conducting a research survey to complete my Plan-B thesis for graduation. I am attempting to gather your views and opinions in regards to the family therapy portion of your program. Please take just a few minutes to fill out the enclosed survey. Remember, it is important for you to fill out the survey completely in order for all data to be accurate. When you are finished please enclose the survey in the envelope provided and return by May 31st. Your cooperation is greatly appreciated! Thank you for your time and consideration.

Sincerely,

Brian Gilson

APPENDIX B
Informed consent

I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I also understand the potential benefits that might be realized from the successful completion of this study. I am aware that the information is being sought in a manner so that no identifiers are needed and so that confidentiality is guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from participation at any time during the study will be respected with no coercion or prejudice.

NOTE: Questions or concerns about participation in the research or subsequent complaints should be addressed first to the researcher or research advisor and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 410 BH, UW-Stout, Menomonie, WI, 54751, phone (715) 232-1126.

APPENDIX C

Please complete this survey in a thorough and timely fashion.
ID# _____

1. What is your age?
   A. Under 35 B. 35-50 C. Over 50
2. What is your gender?
   A. Female B. Male
3. How many years have you been in counseling practice?
   A. Up to 5 years B. 5-10 years C. 10-15 years D. 15+ years
4. How many years of past training or employment in a chemical dependency setting do you have?
   A. < 1 year B. 1-5 years C. > 5 years
5. How many hours per week are you employed as a counselor?
   A. < 20 hours B. 20-29 hours C. > 30 hours
6. How many years have you been in recovery? (Note: this question is optional)
   A. < 3 years B. 3-5 years C. > 5 years
   D. Not in recovery/ Not applicable
7. What type of treatment does your facility provide? (Circle all that apply)
   A. Detoxification B. Inpatient counseling C. Outpatient counseling (wkly)
   D. Long term residential treatment (avg.: 6 mos.) E. Intensive Outpatient
   F. Other (Please list)_____ (daily, every other day, etc.)
   _____
8. What is the average length of stay in your facility? (Note: If answered C or E above please indicate length of involvement.)
   A. ≤ 10 days B. 11-20 days C. 21-30 days D. 1-6 months
   E. > 6 months
9. What is your work/treatment setting? (Circle all that apply)
   A. Private Practice B. Community program C. County funded program
   D. State funded program E. Federal funded program F. Group home setting
   G. Halfway house setting H. Residential treatment setting I. Hospital
   J. Mental health clinic K. Correctional facility
   L. Other (please list)_____
10. Which of these five responses (None, less than half, about half, more than half, all) best describes the proportion of your family program patients that participate in each of the following treatment modalities:
    A._____ Conjoint couples therapy (husband and wife together)
    B._____ Couples group therapy (patients and their spouses)
    C._____ Family therapy (patient, spouse and children)
    D._____ Family group therapy (composed of all attending members of patient's families)
    E._____ Children's therapy group
    F._____ Spouses' therapy group

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ID# _____

10. Continued from previous page.
    G._____ Family education group (composed of all attending members of patient's families)
    H._____ Spouse's education group
    I._____ Children's education group
    J._____ Individual therapy for patient's children
    K._____ Individual therapy for patient's spouse
    L._____ Refer spouse to Al-Anon
    M._____ Refer children to Alateen
    N._____ Other (please list) _____
    _____

11. Which of the following statements best describes your opinions about family programs?
    A. In order for AODA treatment to be successful, the family must be completely involved in the treatment process.
    B. AODA treatment can be successful without family programs, but it is not recommended.
    C. In order for AODA treatment to be successful, it is not necessary to involve families.
    D. In order for AODA treatment to be successful, there needs to be at least minimal family involvement.
    E. In order for AODA treatment to be successful, there needs to be moderate family involvement.

    Comments:_____
    _____

12. If you had to choose which family members were to attend your family program, how would they rank in importance? (please rank 1-8, 1=most important, 8=least)
    A.____ Mother B.____ Spouse/Significant other C.____ Siblings
    D.____ Grandparents E.____ Father F.____ Aunts/Uncles
    G.____ Step-parents H.____ Children

    Comments:_____

13. Does your facility conduct follow-up investigations on its patients?
    A. Yes B. No

    (Note: If your answer is No, please skip #14 & #15)

14a. In your estimation, how many of the patients participating in your family program have remained abstinent for at least 6 months?
    A. None B. Less than half C. About half D. More than half E. All

14b. On what do you base this answer?
    A. Subjective estimation B. Program statistics C. Other (please list)
    _____

15. In your own opinion, how much of this success, or lack of success, can be attributed to your family program?
    A. None B. Less than half C. About half D. More than half E. All

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ID#_____

16. Which of the following statements best describes your satisfaction with your family program?
    A. I am very satisfied with our family program.
    B. I am somewhat satisfied with our family program.
    C. I am somewhat dissatisfied with our family program.
    D. I am very dissatisfied with our family program.

    Comments:_____
    _____

17. If you could, what changes would you make to your family program?
    A. More extensive educational programming.
    B. More support group opportunities.
    C. More emphasis on extended family(grandparents, aunts, uncles, etc.) involvement.
    D. More intensive immediate family involvement
    E. Other (Please list)_____
    _____

18. In your experience, past or present, which of the following best describes the influence of third party funding (private insurance, MA/MC, etc,.) on family involvement in treatment.
    A. No influence/ Neutral B. Positive influence/Encourages family involvement (funds all or most) C. Negative/Discourages family involvement (funding minimal/nonexistent)
    Comments:_____
    _____